

2020 Small Group Plans

IN-NETWORK	PLATINUM HMO 110	SILVER ALIGN OPTIMUM	SILVER ALIGN FLEXIBLE	SILVER POS 8100
Deductible	\$0	\$1,900/\$3,800	\$5,000/\$10,000	\$2,900/\$5,800
Coinsurance	0%	0%	50% after deductible	40% after deductible
Out-of-Pocket Max	\$3,500/\$7,000	\$6,900/\$13,800	\$6,900/\$13,800	\$6,900/\$13,800

OUT-OF-NETWORK				
Deductible	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
Coinsurance	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Out-of-Pocket Max	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000

MEDICAL SERVICES				
Primary Care Office Visits	\$5	\$25 after deductible	50% after deductible	40% after deductible
Specialist Office Visits	\$25	\$50 after deductible	50% after deductible	40% after deductible
Inpatient Hospital Services	\$500 copayment	\$750 after deductible	50% after deductible	40% after deductible
Outpatient Surgery Services	\$20/\$30	\$30/\$50 after deductible	50% after deductible	40% after deductible
Out Patient Facility Fee	\$150	\$150 after deductible	50% after deductible	40% after deductible
Emergency Room	\$100	\$250 after deductible	\$250 after deductible	40% after deductible
Urgent Care	\$40	\$75 after deductible	\$75 after deductible	40% after deductible

PRESCRIPTION DRUGS				
Pharmacy	\$5/\$25/50%	\$5/\$25/50% after deductible	\$5/\$25/50% after deductible	\$5/\$25/50% after deductible

PRODUCT DETAILS				
Wellness Benefits	\$250 per contract	\$250 per contract	\$250 per contract	\$250 per contract

RATES				
Employee Rate	\$620.38	\$439.43	\$439.43	\$424.88
Employee & Child(ren) Rate	\$1054.65	\$747.03	\$747.03	\$722.30
Employee & Spouse Rate	\$1240.76	\$878.86	\$878.86	\$849.76
Family Rate	\$1768.08	\$1252.38	\$1252.38	\$1210.91